If You Have Any Questions

If you have any questions, you may call, write or visit any Social Security office. If you visit an office, please bring this notice and decision with you. The telephone number of the local office that serves your area is (585)232-3890. Its address is Social Security, 100 State St, Room 500, Rochester, NY 14614.

William E. Straub
Administrative Law Judge

cc: Jean Owen
5700 Broadmoor St.,
Suite 310
Mission, KS 66202

Metropolitan Life Insurance Company

MetLife®

MetLife Disability
PO Box 14590
Lexington, KY 40511-4590

February 28, 2006

John Magee
71 Ontario St
Honeoye Falls, NY 14472-1123

RE: ITT Industries, Inc.
Long Term Disability
Claim No.: 640407128904
Group No.: 303299
Emp ID No.: 620820

Dear Mr. Magee:

We are writing in reference to your claim for ITT Industries, Inc.'s Long Term Disability (LTD) benefits.

We require additional information describing your current medical condition to enable us to evaluate your claim for Long Term Disability Benefits.

In accordance with the terms of your group plan, we are asking you to please have Dr. Tariot provide us with your medical records. The medical records should include:

- **Detailed office notes and therapy session notes from Dr. Tariot from May 1, 2005 to present.**
- **List of all medications and dosages you are taking.**
- **Present and future course of treatment.**
- **Completed MetLife Psychiatric Questionnaire forms from your most recent office visit with Dr. Tariot.**

We are also asking you to please have Dr. Tariot answer a few questions:

- **What will your prognosis be in the next six-(6) months?**
- **What is your overall progress in treatment? If your progress has been limited, what alternative treatment modalities are being considered or utilized? If the progress has been positive, please provide an estimate return to work date.**
- **Have there been any referrals?**
- **Do you require a higher level of care?**
- **Are you considered to be seriously and persistently mentally ill?**
- **Are you capable of conducting any work-related activities, in any occupation, at this time?**

We ask that you contact Dr. Tariot's office promptly to be sure this information is submitted on behalf of your claim. Please note that any cost associated with this request is, as always, the responsibility of the claimant. We also ask that you include your Long Term Disability claim number **640407128904** on all forms submitted to our office.

Your cooperation is greatly appreciated.

Sincerely,

Peter Knoth
Case Management Specialist
MetLife DisAbility
(800) 300-4296 - Phone
(800) 230-9531 - Fax

Enclosure:

MetLife®

Name: John Magee
Claim #: 640407128904
DOB: 12/07/1959

Please fax the following information to 800-230-9531. (Please note that any cost associated with obtaining medical records is the responsibility of the claimant.)

- Specific diagnosis Axis I through V with DSM IV-TR or ICD 9 Code.
  Axis I

  Axis II

  Axis III

  Axis IV

  Axis V: Current: _____ Highest in past year: _____
- List medications, response to medications, recent changes in medications and any reported side effects and/or improvements.
- Please describe how this disorder is affecting your patient's ability to perform activities of daily living.

  As evidenced by what objective measures?
- What is your understanding of your patient's primary work responsibilities?
- What specific symptoms, deficits or functional impairments does your patient exhibit that would impair your patient from performing work related activities?

  As evidenced by what objective measures?

- Please describe your treatment plan including:

  Date patient first treated for this condition…
  Frequency of treatments…
  Most recent date of treatment…
  Next scheduled follow up…

  If your patient is not responding well to current treatment plan, what changes are you considering?

- Please provide an estimated return to work date_____.

  Your patient's employer may accommodate a gradual return to work. When do you project your patient would be able to participate in such a plan? _____

- Is there any current or has there been any history of alcohol/drug abuse?
  If yes, how are you addressing this in your patient's treatment plan?

- Have there been any referrals? If so, please provide names and numbers.

Signature _____ Date _____

***** Please provide MetLife with a copy of the progress notes from the past two months to include a complete mental status exam, and the date it was completed. (Include a current suicidal ideation assessment.) *****

Rev.9-17-2004

Metropolitan Life Insurance Company

MetLife®

MetLife Disability
PO Box 14590
Lexington, KY 40511-4590

January 11, 2006

John Magee
71 Ontario St.
Honeoye Falls, NY 14472-1123

RE: ITT Industries, Inc.
Long Term Disability
Claim No.: 640407128
Group No.: 303299
Emp ID No.: 620820

Dear Mr. Magee:

We are writing in reference to your claim for ITT Industries, Inc.'s Long-Term-Disability (LTD) benefits.

We require additional information describing your current medical condition to enable us to evaluate your claim for Long Term Disability Benefits.

In accordance with the terms of your group plan, we are asking you to please have Dr. David Bell provide us with your medical records. The medical records should include:

- **Detailed office visit notes from Dr. David Bell from August 1, 2005 to present.**
- **Diagnostic test procedures performed and the results from August 1, 2005 to present.**
- **List of medications and dosages.**
- **Specific restrictions and limitations preventing you from returning to work.**
- **Present and future course of treatment.**
- **Estimated return to work date.**
- **A completed MetLife Chronic Fatigue Syndrome Initial Functional Assessment form from your most recent office visit with Dr. Bell**

We are also asking you to please have your treating psychiatrist and psychologist provide us with your medical records. The medical records should include:

- **Detailed office notes and therapy session notes from your psychiatrist and psychologist from August 1, 2005 to present.**
- **List of all medications and dosages you are taking.**
- **Present and future course of treatment.**
- **Completed MetLife Psychiatric Questionnaire forms from your most recent office visit with your psychiatrist.**

2/7/06 copies sent

We are also asking you to have your psychiatrist answer a few questions:

- **Ask your treating psychiatrist what your prognosis will be in the next six- (6) months.**
- **What is your overall progress in treatment? If your progress has been limited, what alternative treatment modalities are being considered or utilized? If the progress has been positive, please provide an estimate return to work date.**
- **Have there been any referrals?**
- **Do you require a higher level of care?**
- **Are you considered to be seriously and persistently mentally ill?**
- **Are you capable of conducting any work-related activities, in any occupation, at this time?**

We ask that you contact Dr. David Bell and your treating psychiatrists and psychologist's office's promptly to be sure this information is submitted on behalf of your claim. Please note that any cost associated with this request is, as always, the responsibility of the claimant. We also ask that you include your Long Term Disability claim number **640407128904** on all forms submitted to our office.

Your cooperation is greatly appreciated.

Sincerely,

Peter Knoth
Case Management Specialist
Met DisAbility
(800) 300-4296 - Phone
(800) 230-9531 - Fax

Enclosure:

MetLife Chronic Fatigue Syndrome Initial Functional Assessment

Claimant: John Magee Claim Number: 640407128904 Employer: ITT Industries, Inc.

Provider's Name David S. Bell MD Board Certified Specialty

Provider's Signature [signature] Today's Date 02/06/06

Phone Number 585-765-2060 Fax Number 585-765-2067

Managed Care Affiliate for this client:

First Appt. Date: 09/18/00 Last Appt. Date: 02/06/06 Next Appt. Date:

Date You Determined Disability Began: April 2003

Current ICD 9 Code	Description (please designate if acute or chronic)
Primary Treating Condition(s)	Chronic Fatigue Syndrome, Orthostatic Hypotension
Date First Diagnosed	April 1996 - by Dr. Ross
CDC Criteria Met?	Yes
Secondary Treating Condition	Orthostatic Intolerance
Date First Diagnosed	9/18/00
Criteria for Condition Met?	
Other Medical	Orthostatic Hypotension / Hypovolemia
Psychiatric Condition(s)	
Date Diagnosed	
Psychosocial & Environmental	
Significance of Stressors	

Please include office notes/testing results from to present.

Treatment Regimen

A. Medications B. Exercise C. Labs D. Return to Work Plan

Please indicate use and/or prescription of Antidepressants, Narcotics, Sleep Medications, NSAIDS, Steroids; Injections; Acupuncture; Herbal Remedies; Over the Counter Medications; Ibuprofen/Naprosyn; Physical Therapy; Dietary/Nutritional supplements or restrictions; Exercise Regimen (aquatherapy, walking, low impact aerobics); Other.
If "no" to any of the above please indicate rationale.

A. Medications: History and Current Regimen including OTC

Prescribed/Dosage	Response/Date Ended
Wellbutrin	
Vicodin 10/500	
Celexa 60mg	

METLIFE CHRONIC FATIGUE SYNDROME INITIAL FUNCTIONAL ASSESSMENT

CLAIMANT: JOHN MAGEE CLAIM NUMBER: 640407128904 EMPLOYER: ITT INDUSTRIES, INC.

B. EXERCISE REGIMEN/ALTERNATIVE MEDICINE/ RESPONSE/DATE ENDED

C. DATE AND RESULTS OF MOST RECENT LABS: CBC; TSH; LYME; ANA;ETC.

6/29/05		

D. RETURN TO WORK/GOALS AND DATE

What specific symptoms, deficits, or functional impairments are prohibiting the individual from returning to his/her job?	unable to sustain activity extreme fatigue cognitive difficulties
Please address how the current treatment plan actively addresses the above impairment?	unlikely to improve
Please provide a prognosis and Estimated date for return to work (Part-time or Full-time	marked disability
Please specify types of reasonable accommodations and the expected duration that would facilitate a re-entry into the work place	would need prolonged rest
Could this patient currently perform the same job in another department or division of the company?	YES ☐ NO ☒ (please explain why not) unable to sustain activity
Could this patient currently perform the same job at a different company?	YES ☐ NO ☒ (please explain why not) unable to sustain activity
What other healthcare professionals are actively involved in the care of the patient? Please explain.	YES ☒ (name/address/phone) NO ○ (please explain why not) Carolyn Cerame

METLIFE CHRONIC FATIGUE SYNDROME INITIAL FUNCTIONAL ASSESSMENT
CLAIMANT: JOHN MAGEE   CLAIM NUMBER: 640407128904   EMPLOYER: ITT INDUSTRIES, INC.

BASED ON YOUR MOST RECENT EVALUATION OF THE PATIENT'S CLINICAL FUNCTIONAL STATUS, PROVIDE YOUR OBJECTIVE OPINION OF THIS PATIENT'S <u>CURRENT DEGREE OF SYMPTOMS.</u>

Have you evaluated the patient's job description? ☒ Yes ☐ No
Have you had your patient maintain an energy /fatigue level journal? ☐ Yes ☒ No

0	Minimal 0-20% of the time
1	Mild 21-30% of the time
2	Moderate 31-50% of the time
3	Moderate to severe 51-75% of the time
4	Severe 76-100% of the time

Current Symptoms/Complaints	Any Comments, i.e., Time(s) Diffuse or Specific Acute or Stable	0	1	2	3	4
Fatigue		☐	☐	☐	☐	☒
Muscular pain		☐	☐	☐	☐	☒
Multiple joint pain		☐	☐	☐	☐	☒
Tender lymph nodes		☐	[scribbled out]	☐	☐	☒
Sore throat		☐	☒	☐	☐	☐
Unrefreshed sleep		☐	☐	☐	☐	☒
Post-exertional malaise		☐	☐	☐	☐	☒
Energy loss		☐	☐	☐	☐	☒
Pain on bending		☐	☐	☐	☐	☒
Pain when using upper body		☐	☐	☐	☐	☒
Pain when using lower body		☐	☐	☐	☐	☒
Pain when driving	does not drive much	☐	☐	☐	☒	☐
Headaches/location		☐	☐	☐	☐	☒
Photophobia		☐	☐	☐	☐	☒
Depression		☐	☒	☐	☐	☐
Mood swings		☒	☐	☐	☐	☐
Poor concentration		☐	☐	☐	☐	☒
Memory lapses		☐	☐	☐	☐	☒
Anxiety		☒	☐	☐	☐	☐
Panic Attacks		☒	☐	☐	☐	☐
Alcohol Use		☒	☐	☐	☐	☐
Drug abuse		☒	☐	☐	☐	☐
Sexual dysfunction		☒	☐	☐	☐	☐
Dry eyes	uses eye drops	☒	☐	☐	☐	☐
Dry mouth		☐	☐	☒	☐	☐
Circulatory difficulties		☐	☐	☐	☐	☐ ?
Skin irritations		☒	☐	☐	☐	☐

METLIFE CHRONIC FATIGUE SYNDROME INITIAL FUNCTIONAL ASSESSMENT

CLAIMANT: JOHN MAGEE CLAIM NUMBER: 640407128904 EMPLOYER: ITT INDUSTRIES, INC.

Change with weather		☐	☐	☒	☐	☐
Chemical sensitivity		☐	☐	☐	☒	☐

Date of Visit: 1/25/06 Visited 2/6/04
Age: 46
Med Allergies: Codeine + Iodine

NAME: Magee, John

David S. Bell MD, FAAP
77 South Main Street,
Lyndonville, NY 14098
585-765-2060

Medications: See Symptom Rating Form

HPI & Chief Complaint: Symptoms: CFS, disability forms
Location:
Quality:
Severity: no changes
Duration:
Other:

ROS:

Fever:	Chills:	Earache:	Sore Throat:
Cough:	Chest Pain:	SOB:	Hemoptysis:
Vomiting:	Diarrhea:	Nausea:	Constipation:
Dysuria:	Rash:	Muscle Pain:	Joint Pain:
Fatigue:	Depression:	Anxiety:	

CFS & FM: see full symptom questionnaire

Interval History/Family History:

Past Surgeries:

Social History: Smoke: ETOH: Drug:

Physical Exam: General:

Wt: 250 Hgt: HC:
T: 94.9 P: 76 R: 16 BP: 124/84

Eyes: ✓
Ears: ✓
Throat: ✓
Neck: ✓ bruits: thyroid:
Chest: ✓
Heart: ✓
Abdomen: ✓
Skin: ✓
GU: ✓ Neuro:
Psych: ✓ Mood: Affect:

Counseling Done (time/min):

Assessment

1) CFS
2)
3)
4)

Plan:

1) forms
2)
3)
4)

Time spent:

ML0319

Date of Visit: 12/2/05
Age: reached by patient 12/7/05
Med Allergies:

NAME: Magee, John

David S. Bell MD, FAAP
77 South Main Street,
Lyndonville, NY 14098
585-765-2060

Medications:

HPI & Chief Complaint: Symptoms: CFS
Location:
Quality:
Severity:
Duration:
Other:

ROS:
Fever: Chills: Earache: Sore Throat:
Cough: Chest Pain: SOB: Hemoptysis:
Vomiting: Diarrhea: Nausea: Constipation:
Dysuria: Rash: Muscle Pain: Joint Pain:
Fatigue: Depression: Anxiety:

CFS & FM: see full symptom questionnaire

Interval History/Family History:

Past Surgeries:

Social History: Smoke: no ETOH: occas Drug:

Physical Exam: General:

Eyes:
Ears:
Throat:
Neck: bruits: thyroid:
Chest:
Heart:
Abdomen:
Skin:
GU: Neuro:
Psych: Mood: Affect:

Wt:	Hgt:	HC:
T:	P: 92 R: 16	BP: 126/76

Counseling Done (time/min):
Advice

Assessment

1) CFS
2)
3)
4)

Plan:

1) Vicodin 10/500 1 PO TID PRN pain #90 5 RF
2)
3)
4)

Time spent:

David S. Bell, MD, FAAP
77 South Main Street
PO Box 495
Lyndonville, New York 14098
585-765-2060 fax 585-765-2067

November 9, 2005

John Magee
71 Ontario Street
Honeoye Falls, NY 14472

Dear John,

We last saw you July 8, 2005 and at the present time it does not appear that we are really being much benefit for you. I am concerned that you are continuing the Vicodin at fairly substantial levels and that in the long run this is not going to be good for you. We are including a prescription for Vicodin 10/500 one tablet three times a day, number 90 with no refills. However, I would like to suggest that you find a local physician who is able to assume your health care and pain medications as I am beginning to move toward retirement. I am sending this letter because I do not want to surprise you by suddenly not being available in the near future. I hope you are well and I wish you the best.

Very truly yours,

David S. Bell, MD

DSB/ds
Encl.

I /CFS Clinical Study Group Questioi ire

David S. Bell MD, FAAP
77 South Main Street,
Lyndonville, NY 14098
716-765-2060
fax 716-765-2067

Name: John Magee **Age:** 46 **Date:** 2/6/06

Thank you for completing this questionnaire, which is being used to collect information about ME/CFS/FM in several clinical practices. If used for research purposes, your confidentiality will be maintained. There are a number of separate sections, and each is designed to give information concerning your pattern of symptoms, and this questionnaire should take about a half an hour to complete. Please bring the completed questionnaire to your next office visit. Do not hesitate to call if you have specific questions.

1. Please list all medications you are taking:
Wellbutrin eye drops (for glaucoma)
celexa
Vicodine

2. Since your last visit here, have you been diagnosed with any other illnesses? If yes, please describe:
no

3. Are you working or in school full time, part time, or not at all?
not at all

4. Is there any significant change in your pattern of symptoms since your last visit?
no

Krupp Fatigue Questionnaire

Please read each statement and circle a number from 1 to 7, depending on how appropriate the statement is to you in the preceding week. A low value indicates that the statement is not very appropriate whereas a high value indicates agreement.	Score
1. My motivation is lower when I am fatigued.	1 2 3 4 5 6 (7)
2. Exercise brings on my fatigue.	1 2 3 4 5 6 (7)
3. I am easily fatigued.	1 2 3 4 5 (6) 7
4. Fatigue interferes with my physical functioning.	1 2 3 4 5 (6) 7
5. Fatigue causes frequent problems for me.	1 2 3 4 5 (6) 7
6. My fatigue prevents sustained physical functioning.	1 2 3 4 5 6 (7)
7. Fatigue interferes with carrying out certain duties and responsibilities.	1 2 3 4 5 6 (7)
8. Fatigue is among my three most disabling symptoms.	1 2 3 4 5 6 (7)
9. Fatigue interferes with my work, family, or social life.	1 2 3 4 5 6 (7)

Activity Scale: Please check the one area that most closely describes your activity over the past week. If your activity varies during a typical week, check the area that describes your average daily activity.

_____ 100%: I feel very well and able to do all activities. I am not limited by fatigue or exhaustion at all.

_____ 90%: I feel well but will have mild fatigue on heavy exertion or exercise that disappears with rest.

_____ 80%: I generally feel well, but notice mild fatigue fairly often. It does not prevent or interrupt normal activities during the day. I still can work or go to school full time.

_____ 70%: I feel OK most of the time but frequently have fatigue which interferes with my daily activities. I have to rest more than I should, but I still can work or go to school full time.

_____ 60%: I frequently feel ill and have had to reduce my activities because of fatigue and exhaustion. I work or go to school but it is difficult and I need to rest more often. The fatigue clearly interferes with my daily activities.

_____ 50%: I feel moderately ill much of the time, and the fatigue and exhaustion has a definite impact on my life. I am not able to consistently put in eight hours of work or school every day. I have had to reduce my daily activities substantially.

_____ 40%: I feel ill nearly all of the time and the fatigue and exhaustion have forced me to limit my activities or carefully plan them. I cannot work or go to school except for part time. I have to rest much of the day.

__X__ 30%: I feel ill most of the time and am unable to even leave the house except for a few hours a day. I am unable to work or go to school. I spend most of the day resting.

_____ 20%: I feel extremely ill nearly all day, and am unable to leave the house except rarely. I spend nearly all day resting. I am able to do light activities such as preparing food for only one or two hours a day.

_____ 10%: I am bed-ridden and feel extremely ill all of the time. I need help with activities of daily living.

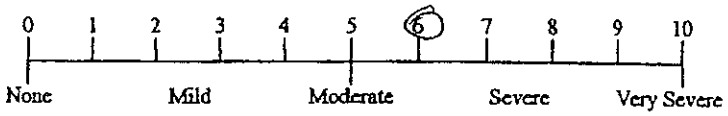
_____ 0%: I am extremely ill all of the time and must have constant care for activities such as eating or bathing. I cannot prepare my own food, and do not leave the house.

Thank you for completing this questionnaire.

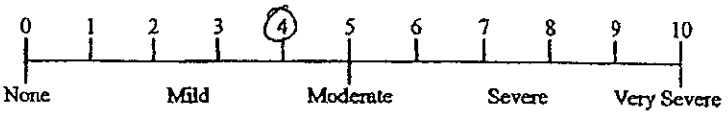
Krupp: _____ SF-36: _____ 9 item VAS: _____ Modified Karnofsky: _____

Specific Symptom Severity Please mark the scale the degree that the symptom has affected you in the past week. If the symptom varies day-to-day, mark an average severity.

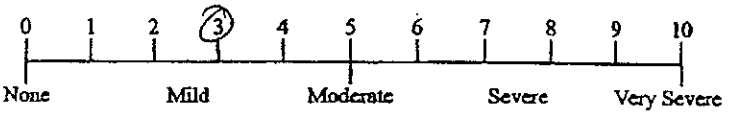
Impaired Memory or Concentration



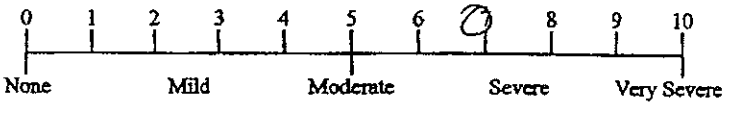
Recurrent sore throat



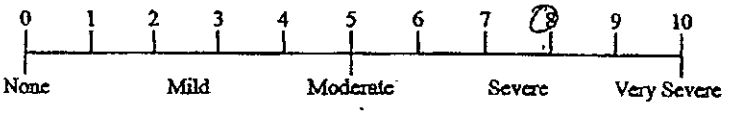
Tenderness in the Lymph Nodes



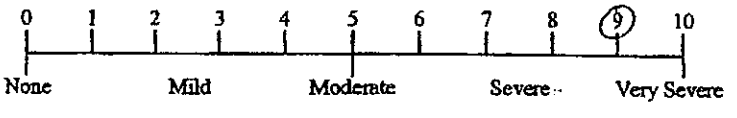
Muscle tenderness



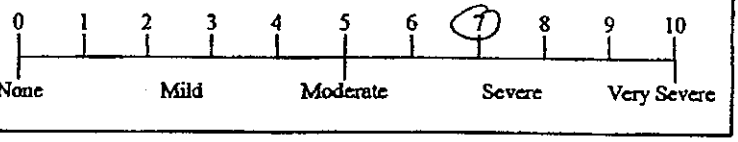
Joint Pain Without Swelling or Redness



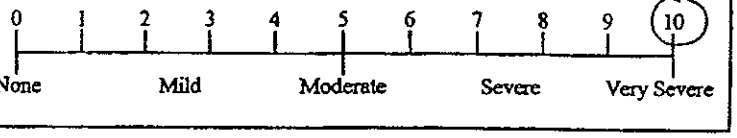
Headache



Unrefreshing sleep



Post-exertional Malaise



RAND 36-Item Health Survey 1. RAND® is a registered trademark.

1. In general, would you say your health is:	
Excellent	1
Very good	2
Good	3
Fair	4
Poor	(5)

2. Compared to one year ago, how would your rate your health in general now?	
Much better now than one year ago	1
Somewhat better now than one year ago	2
About the same	3
Somewhat worse now than one year ago	(4)
Much worse now than one year ago	5

The following items are about activities you might do during a typical day. Does **your health now limit you** in these activities? If so, how much? **(Circle One Number on Each Line)**

	Yes, Limited a Lot	Yes, Limited a Little	No, Not limited at All
3. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	(1)	[2]	[3]
4. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	(1)	[2]	[3]
5. Lifting or carrying groceries	[1]	(2)	[3]
6. Climbing several flights of stairs	(1)	[2]	[3]
7. Climbing one flight of stairs	[1]	(2)	[3]
8. Bending, kneeling, or stooping	[1]	(2)	[3]
9. Walking more than a mile	(1)	[2]	[3]
10. Walking several blocks	(1)	[2]	[3]

11. Walking one block	[1]	[2]	[3]
12. Bathing or dressing yourself	[1]	[2]	[3]

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health? **(Circle One Number on Each Line)**

	Yes	No
13. Cut down the amount of time you spent on work or other activities	1	2
14. Accomplished less than you would like	1	2
15. Were limited in the kind of work or other activities	1	2
16. Had difficulty performing the work or other activities (for example, it took extra effort)	1	2

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)? **(Circle One Number on Each Line)**

	Yes	No
17. Cut down the amount of time you spent on work or other activities	1	2
18. Accomplished less than you would like	1	2
19. Didn't do work or other activities as carefully as usual	1	2

20. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups? (Circle One)

Not at all 1 Slightly 2 Moderately 3 Quite a bit 4 Extremely 5

21. How much bodily pain have you had during the past 4 weeks? (Circle One)

None 1 Very mild 2 Mild 3 Moderate 4 Severe 5 Very severe 6

22. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)? (Circle One Number)

Not at all 1 A little bit 2 Moderately 3 Quite a bit 4 Extremely 5

These questions are about how I feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks . . . (Circle One Number on Each Line)

	All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
23. Did you feel full of pep?	1	2	3	4	5	(6)
24. Have you been a very nervous person?	1	2	3	4	5	(6)
25. Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	(5)	6
26. Have you felt calm and peaceful?	1	2	3	(4)	5	6
27. Did you have a lot of energy?	1	2	3	4	(5)	6
28. Have you felt downhearted and blue?	1	2	3	4	(5)	6
29. Did you feel worn out?	1	(2)	3	4	5	6
30. Have you been a happy person?	1	2	(3)	4	5	6
31. Did you feel tired?	1	(2)	3	4	5	6

32. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)? (Circle One)

All of the time 1 (Most of the time 2) Some of the time 3 A little of the time 4 None of the time 5

How TRUE or FALSE is <u>each</u> of the following statements for you (Circle One Number on Each Line)

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
33. I seem to get sick a little easier than other people	1	2	(3)	>4	5
34. I am as healthy as anybody I know	1	2	3	(4)	5
35. I expect my health to get worse	1	2	(3)	4	5
36. My health is excellent	1	>2	3	4	(5)

M CFS Clinical Study Group Questionnaire

David S. Bell MD, FAAP
77 South Main Street,
Lyndonville, NY 14098
716-765-2060
fax 716-765-2067

Name: John Magee **Age:** 46 **Date:** 12/7/05

Thank you for completing this questionnaire, which is being used to collect information about ME/CFS/FM in several clinical practices. If used for research purposes, your confidentiality will be maintained. There are a number of separate sections, and each is designed to give information concerning your pattern of symptoms, and this questionnaire should take about a half an hour to complete. Please bring the completed questionnaire to your next office visit. Do not hesitate to call if you have specific questions.

1. Please list all medications you are taking:
Wellbutrin Vicoden
Celexa
timoptic

2. Since your last visit here, have you been diagnosed with any other illnesses? If yes, please describe:

3. Are you working or in school full time, part time, or not at all?
not @ all

4. Is there any significant change in your pattern of symptoms since your last visit?
no

Krupp Fatigue Questionnaire

Please read each statement and circle a number from 1 to 7, depending on how appropriate the statement is to you in the preceding week. A low value indicates that the statement is not very appropriate whereas a high value indicates agreement.	Score
1. My motivation is lower when I am fatigued.	1 2 3 4 5 6 (7)
2. Exercise brings on my fatigue.	1 2 3 4 5 6 (7)
3. I am easily fatigued.	1 2 3 4 5 6 (7)
4. Fatigue interferes with my physical functioning.	1 2 3 4 5 6 (7)
5. Fatigue causes frequent problems for me.	1 2 3 4 5 6 (7)
6. My fatigue prevents sustained physical functioning.	1 2 3 4 5 6 (7)
7. Fatigue interferes with carrying out certain duties and responsibilities.	1 2 3 4 5 6 (7)
8. Fatigue is among my three most disabling symptoms.	1 2 3 4 5 6 (7)
9. Fatigue interferes with my work, family, or social life.	1 2 3 4 5 6 (7)

Activity Scale: Please check the one area that most closely describes your activity over the past week. If your activity varies during a typical week, check the area that describes your average daily activity.

_____ 100%: I feel very well and able to do all activities. I am not limited by fatigue or exhaustion at all.

_____ 90%: I feel well but will have mild fatigue on heavy exertion or exercise that disappears with rest.

_____ 80%: I generally feel well, but notice mild fatigue fairly often. It does not prevent or interrupt normal activities during the day. I still can work or go to school full time.

_____ 70%: I feel OK most of the time but frequently have fatigue which interferes with my daily activities. I have to rest more than I should, but I still can work or go to school full time.

_____ 60%: I frequently feel ill and have had to reduce my activities because of fatigue and exhaustion. I work or go to school but it is difficult and I need to rest more often. The fatigue clearly interferes with my daily activities.

_____ 50%: I feel moderately ill much of the time, and the fatigue and exhaustion has a definite impact on my life. I am not able to consistently put in eight hours of work or school every day. I have had to reduce my daily activities substantially.

_____ 40%: I feel ill nearly all of the time and the fatigue and exhaustion have forced me to limit my activities or carefully plan them. I cannot work or go to school except for part time. I have to rest much of the day.

X 30%: I feel ill most of the time and am unable to even leave the house except for a few hours a day. I am unable to work or go to school. I spend most of the day resting.

_____ 20%: I feel extremely ill nearly all day, and am unable to leave the house except rarely. I spend nearly all day resting. I am able to do light activities such as preparing food for only one or two hours a day.

_____ 10%: I am bed-ridden and feel extremely ill all of the time. I need help with activities of daily living.

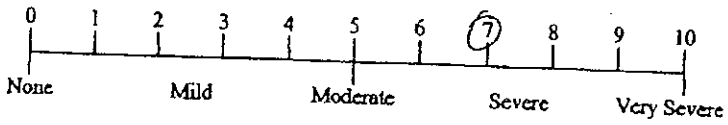
_____ 0%: I am extremely ill all of the time and must have constant care for activities such as eating or bathing. I cannot prepare my own food, and do not leave the house.

Thank you for completing this questionnaire.

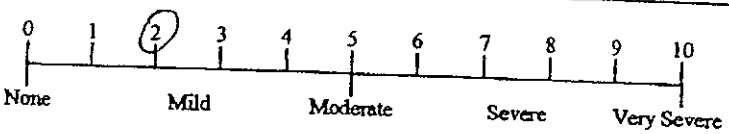
Krupp: _____ SF-36: _____ 9 item VAS: _____ Modified Karnofsky: _____

Specific Symptom Severity. Please mark the scale the degree that the symptom has affected you in the past week. If the symptom varies day-to-day, mark an average severity.

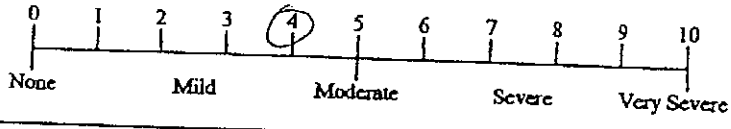
Impaired Memory or Concentration



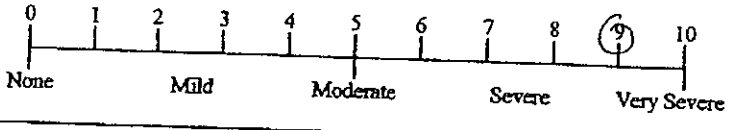
Recurrent sore throat



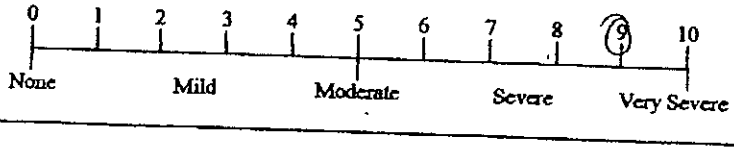
Tenderness in the Lymph Nodes



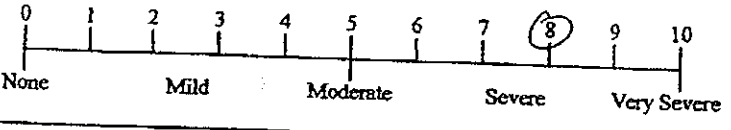
Muscle tenderness



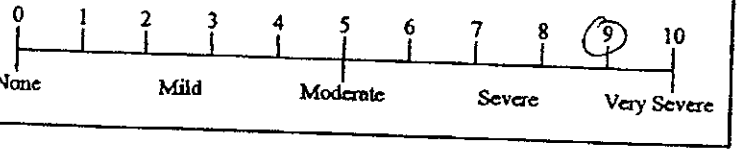
Joint Pain Without Swelling or Redness



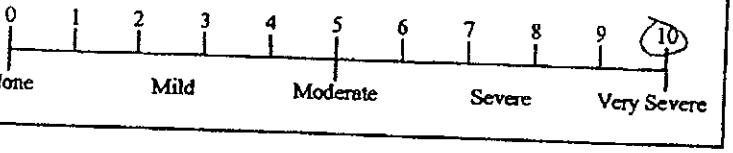
Headache



Unrefreshing sleep



Post-exertional Malaise



RAND 36-Item Health Survey 1.0 RAND® is a registered trademark.

1. In general, would you say your health is:	
Excellent	1
Very good	2
Good	3
Fair	4
Poor	5

2. Compared to one year ago, how would your rate your health in general now?	
Much better now than one year ago	1
Somewhat better now than one year ago	2
About the same	3
Somewhat worse now than one year ago	4
Much worse now than one year ago	5

The following items are about activities you might do during a typical day. Does **your health now limit you** in these activities? If so, how much? **(Circle One Number on Each Line)**

	Yes, Limited a Lot	Yes, Limited a Little	No, Not limited at All
3. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	[1]	[2]	[3]
4. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	[1]	[2]	[3]
5. Lifting or carrying groceries	[1]	[2]	[3]
6. Climbing several flights of stairs	[1]	[2]	[3]
7. Climbing one flight of stairs	[1]	[2]	[3]
8. Bending, kneeling, or stooping	[1]	[2]	[3]
9. Walking more than a mile	[1]	[2]	[3]
10. Walking several blocks	[1]	[2]	[3]

11. Walking one block	[1]	[2]	[3]
12. Bathing or dressing yourself	[1]	[2]	[3]

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health? **(Circle One Number on Each Line)**

	Yes	No
13. Cut down the amount of time you spent on work or other activities	1	2
14. Accomplished less than you would like	1	2
15. Were limited in the kind of work or other activities	1	2
16. Had difficulty performing the work or other activities (for example, it took extra effort)	1	2

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)? **(Circle One Number on Each Line)**

	Yes	No
17. Cut down the amount of time you spent on work or other activities	1	2
18. Accomplished less than you would like	1	2
19. Didn't do work or other activities as carefully as usual	1	2

20. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups? (Circle One)

Not at all 1 Slightly 2 Moderately 3 Quite a bit 4 Extremely 5

21. How much bodily pain have you had during the past 4 weeks? (Circle One)

None 1 Very mild 2 Mild 3 Moderate 4 Severe 5 Very severe 6

22. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)? (Circle One Number)

Not at all 1 A little bit 2 Moderately 3 Quite a bit 4 Extremely 5

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks . . . (Circle One Number on Each Line)

	All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
23. Did you feel full of pep?	1	2	3	4	5	(6)
24. Have you been a very nervous person?	1	2	3	4	5	(6)
25. Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	(5)	6
26. Have you felt calm and peaceful?	1	2	3	(4)	5	6
27. Did you have a lot of energy?	1	2	3	4	5	(6)
28. Have you felt downhearted and blue?	1	2	3	4	(5)	6
29. Did you feel worn out?	1	(2)	3	4	5	6
30. Have you been a happy person?	1	2	3	(4)	5	6
31. Did you feel tired?	1	(2)	3	4	5	6

32. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)? (Circle One)

All of the time 1 Most of the time 2 (Some of the time 3) A little of the time 4 None of the time 5

How TRUE or FALSE is each of the following statements for you. (Circle One Number on Each Line)

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
33. I seem to get sick a little easier than other people	1	2	3	(>4)	5
34. I am as healthy as anybody I know	1	2	3	(4)	5
35. I expect my health to get worse	1	2	(3)	4	5
36. My health is excellent	1	>2	3	4	(5)

060206F07031

Carolyn M. Cerame, CSW, ACSW

253 Alexander Street
Normandie Carriage House
Rochester, New York 14607

(716) 423-9460 (716) 251-7489 voicemail

February 6, 2006

MetLife Claims
Fax: 1-800-230-9531
RE: MAGEE, John
D.O.B. 12/7/59

To Whom It May Concern:

John Magee has only been able to actually come in one time (8/5/05) since July 2005. He has had to cancel a number of times due to his ongoing struggle with extreme exhaustion and pain. As you know, per his medical records, that he is on an array of medications to help stabilize his depression and pain. He describes how difficult it is to not be able to join his family in their activities. He will have to pace his experiences. He knows that if he spends time with the family in an activity, he will be unable to function for several days. He spends most of his time on the couch. His wife, Renee, is wonderful. She really works hard on many fronts. He is very self-critical that he is unable to do more. They are financially and emotionally very strapped. I do not charge him a co-payment, as they cannot afford it. I allow him to cancel or miss any session even without notice, as he often cannot remember when his sessions are.

I have been practicing for twenty years, and I have never had a client who made a more heroic effort. He struggles every day. He is an excellent father and husband. His pain is excruciating. It would be helpful if he could make it to therapy more often, but he cannot manage that at this time.

Please do not hesitate to contact me if you need more information.

Sincerely,

Carolyn M. Cerame, LCSW-R, ACSW

OOC

Metropolitan Life Insurance Company

MetLife®

MetLife Disability
PO Box 14590
Lexington, KY 40511-4590

January 11, 2006

John Magee
71 Ontario St.
Honeoye Falls, NY 14472-1123

RE: ITT Industries, Inc.
Long Term Disability
Claim No.: 640407128904
Group No.: 303299
Emp ID No.: 620820

Dear Mr. Magee:

We are writing in reference to your claim for ITT Industries, Inc.'s Long-Term-Disability (LTD) benefits.

We require additional information describing your current medical condition to enable us to evaluate your claim for Long Term Disability Benefits.

In accordance with the terms of your group plan, we are asking you to please have Dr. David Bell provide us with your medical records. The medical records should include:

- **Detailed office visit notes from Dr. David Bell from August 1, 2005 to present.**
- **Diagnostic test procedures performed and the results from August 1, 2005 to present.**
- **List of medications and dosages.**
- **Specific restrictions and limitations preventing you from returning to work.**
- **Present and future course of treatment.**
- **Estimated return to work date.**
- **A completed MetLife Chronic Fatigue Syndrome Initial Functional Assessment form from your most recent office visit with Dr. Bell**

We are also asking you to please have your treating psychiatrist and psychologist provide us with your medical records. The medical records should include:

- **Detailed office notes and therapy session notes from your psychiatrist and psychologist from August 1, 2005 to present.**
- **List of all medications and dosages you are taking.**
- **Present and future course of treatment.**
- **Completed MetLife Psychiatric Questionnaire forms from your most recent office visit with your psychiatrist.**

We are also asking you to have your psychiatrist answer a few questions:

- **Ask your treating psychiatrist what your prognosis will be in the next six- (6) months.**
- **What is your overall progress in treatment? If your progress has been limited, what alternative treatment modalities are being considered or utilized? If the progress has been positive, please provide an estimate return to work date.**
- **Have there been any referrals?**
- **Do you require a higher level of care?**
- **Are you considered to be seriously and persistently mentally ill?**
- **Are you capable of conducting any work-related activities, in any occupation, at this time?**

We ask that you contact Dr. David Bell and your treating psychiatrists and psychologist's office's promptly to be sure this information is submitted on behalf of your claim. Please note that any cost associated with this request is, as always, the responsibility of the claimant. We also ask that you include your Long Term Disability claim number **640407128904** on all forms submitted to our office.

Your cooperation is greatly appreciated.

Sincerely,

Peter Knoth
Case Management Specialist
Met DisAbility
(800) 300-4296 - Phone
(800) 230-9531 - Fax

Enclosure:

MetLife®

Name: John Magee
Claim #: 640407128904
DOB: 12/07/1959

Please fax the following information to 800-230-9531. (Please note that any cost associated with obtaining medical records is the responsibility of the claimant.)

- Specific diagnosis Axis I through V with DSM IV-TR or ICD 9 Code.
  Axis I

  Axis II

  Axis III

  Axis IV

  Axis V: Current: ___________ Highest in past year: _____________

- List medications, response to medications, recent changes in medications and any reported side effects and/or improvements.

- Please describe how this disorder is affecting your patient's ability to perform activities of daily living.

  As evidenced by what objective measures?

- What is your understanding of your patient's primary work responsibilities?

- What specific symptoms, deficits or functional impairments does your patient exhibit that would impair your patient from performing work related activities?

  As evidenced by what objective measures?

- Please describe your treatment plan including:

  Date patient first treated for this condition…
  Frequency of treatments…
  Most recent date of treatment…
  Next scheduled follow up…

  If your patient is not responding well to current treatment plan, what changes are you considering?

- Please provide an estimated return to work date_____.

  Your patient's employer may accommodate a gradual return to work. When do you project your patient would be able to participate in such a plan? _____

- Is there any current or has there been any history of alcohol/drug abuse?
  If yes, how are you addressing this in your patient's treatment plan?

- Have there been any referrals? If so, please provide names and numbers.

Signature _____ Date _____

***** Please provide MetLife with a copy of the progress notes from the past two months to include a complete mental status exam, and the date it was completed.**
(Include a current suicidal ideation assessment.) ***

Rev.9-17-2004

MetLife Chronic Fatigue Syndrome Initial Functional Assessment

Claimant: John Magee Claim Number: 640407128904 Employer: ITT Industries, Inc.

Provider's Name _____ Board Certified Specialty _____

Provider's Signature _____ Today's Date _____

Phone Number _____ Fax Number _____

Managed Care Affiliate for this client: _____

First Appt. Date: _____ Last Appt. Date: _____ Next Appt. Date: _____

Date You Determined Disability Began: _____

Current ICD 9 Code	Description (please designate if acute or chronic)
Primary Treating Condition(s)	
Date First Diagnosed	
CDC Criteria Met?	
Secondary Treating Condition	
Date First Diagnosed	
Criteria for Condition Met?	
Other Medical	
Psychiatric Condition(s)	
Date Diagnosed	
Psychosocial & Environmental	
Significance of Stressors	

Please include office notes/testing results from to present.

Treatment Regimen

A. Medications B. Exercise C. Labs D. Return to Work Plan

Please indicate use and/or prescription of Antidepressants, Narcotics, Sleep Medications, NSAIDS, Steroids; Injections; Acupuncture; Herbal Remedies; Over the Counter Medications; Ibuprofen/Naprosyn; Physical Therapy; Dietary/Nutritional supplements or restrictions; Exercise Regimen (aquatherapy, walking, low impact aerobics); Other.
If "no" to any of the above please indicate rationale.

A. Medications: History and Current Regimen including OTC

Prescribed/Dosage	Response/Date Ended

METLIFE CHRONIC FATIGUE SYNDROME INITIAL FUNCTIONAL ASSESSMENT

CLAIMANT: JOHN MAGEE CLAIM NUMBER: 640407128904 EMPLOYER: ITT INDUSTRIES, INC.

B. EXERCISE REGIMEN/ALTERNATIVE MEDICINE/ RESPONSE/DATE ENDED

C. DATE AND RESULTS OF MOST RECENT LABS: CBC; TSH; LYME; ANA;ETC.

D. RETURN TO WORK/GOALS AND DATE

What specific symptoms, deficits, or functional impairments are prohibiting the individual from returning to his/her job?	
Please address how the current treatment plan actively addresses the above impairment?	
Please provide a prognosis and Estimated date for return to work (Part-time or Full-time	
Please specify types of reasonable accommodations and the expected duration that would facilitate a re-entry into the work place	
Could this patient currently perform the same job in another department or division of the company?	**YES ☐ NO ○ (please explain why not)**
Could this patient currently perform the same job at a different company?	**YES ☐ NO ○ (please explain why not)**
What other healthcare professionals are actively involved in the care of the patient? Please explain.	**YES ☐ (name/address/phone) NO ○ (please explain why not)**

MetLife Chronic Fatigue Syndrome Initial Functional Assessment

Claimant: John Magee Claim Number: 640407128904 Employer: ITT Industries, Inc.

Based on your most recent evaluation of the patient's clinical functional status, provide your objective opinion of this patient's Current Degree of Symptoms.

Have you evaluated the patient's job description? ☐ Yes ☐ No
Have you had your patient maintain an energy /fatigue level journal? ☐ Yes ☐ No

0	Minimal 0-20% of the time
1	Mild 21-30% of the time
2	Moderate 31-50% of the time
3	Moderate to severe 51-75% of the time
4	Severe 76-100% of the time

Current Symptoms/Complaints	Any Comments, i.e., Time(s) Diffuse or Specific Acute or Stable	0	1	2	3	4
Fatigue		☐	☐	☐	☐	☐
Muscular pain		☐	☐	☐	☐	☐
Multiple joint pain		☐	☐	☐	☐	☐
Tender lymph nodes		☐	☐	☐	☐	☐
Sore throat		☐	☐	☐	☐	☐
Unrefreshed sleep		☐	☐	☐	☐	☐
Post-exertional malaise		☐	☐	☐	☐	☐
Energy loss		☐	☐	☐	☐	☐
Pain on bending		☐	☐	☐	☐	☐
Pain when using upper body		☐	☐	☐	☐	☐
Pain when using lower body		☐	☐	☐	☐	☐
Pain when driving		☐	☐	☐	☐	☐
Headaches/location		☐	☐	☐	☐	☐
Photophobia		☐	☐	☐	☐	☐
Depression		☐	☐	☐	☐	☐
Mood swings		☐	☐	☐	☐	☐
Poor concentration		☐	☐	☐	☐	☐
Memory lapses		☐	☐	☐	☐	☐
Anxiety		☐	☐	☐	☐	☐
Panic Attacks		☐	☐	☐	☐	☐
Alcohol Use		☐	☐	☐	☐	☐
Drug abuse		☐	☐	☐	☐	☐
Sexual dysfunction		☐	☐	☐	☐	☐
Dry eyes		☐	☐	☐	☐	☐
Dry mouth		☐	☐	☐	☐	☐
Circulatory difficulties		☐	☐	☐	☐	☐
Skin irritations		☐	☐	☐	☐	☐

METLIFE CHRONIC FATIGUE SYNDROME INITIAL FUNCTIONAL ASSESSMENT

CLAIMANT: JOHN MAGEE CLAIM NUMBER: 640407128904 EMPLOYER: ITT INDUSTRIES, INC.

Change with weather		☐	☐	☐	☐	☐
Chemical sensitivity		☐	☐	☐	☐	☐

Employee SS No.	Employee Birthdate	Employee Last Name	Employee First Name
[redacted]			
088544213	12/7/59	Magee	John C.
[redacted]			

Date of Visit: 7/8/05
Age: 45
Med Allergies: Codeine, Iodine **NAME:** Mazu John

David S. Bell MD, FAAP
77 South Main Street,
Lyndonville, NY 14098
585-765-2060

Medications: on same meds.
Trazadone @ hs.

HPI & Chief Complaint: Symptoms: CFS MV
Location:
Quality:
Severity:
Duration:
Other:

ROS:
Fever: ⊖ Chills: ⊖ Earache: ⊖ Sore Throat: ⊖
Cough: ⊖ Chest Pain: ⊖ SOB: ⊖ Hemoptysis: ⊖
Vomiting: ⊖ Diarrhea: ⊖ Nausea: ⊖ Constipation: ⊖
Dysuria: ⊖ Rash: ⊖ Muscle Pain: ⊖ Joint Pain: ⊖
Fatigue: Depression: Anxiety:

CFS & FM: see full symptom questionnaire

Interval History:

Past Surgeries:

Social History: Smoke: ETOH: Drug:

Physical Exam: General:

Wt: 242 lbs. Hgt: HC:
T: 97.8 P: 82 R: 20 BP: 132/72

Eyes: ✓ normal
Ears: ✓ normal
Throat: ✓ normal
Neck: ✓ normal bruits: thyroid:
Chest: ✓
Heart: ✓
Abdomen: ✓
Skin: ✓
GU: ✓ Neuro:
Psych: Mood: Affect:

Counseling Done (time/min): 60 min Sec directed As 30 min JRF

Assessment
1) Hypothyroidism
2)
3)
4)
5)

Plan: 1) synthroid 75 mcg
2) Vicodin 10/500
3)
4)
5)

Time spent:

ML0344

CMS H M05165508301

Date of Visit: 5/25/05 reached wy 6/1/05
Age: 45
Med Allergies: Codeine, Iodine

NAME: Magee, John

David S. Bell MD, FAAP
77 South Main Street,
Lyndonville, NY 14098
585-765-2060

Medications: See Symp Rating Form

HPI & Chief Complaint: Symptoms: CFS rel, orthost hypo. on disability
Location:
Quality: severe dizziness
Severity:
Duration:
Other:

ROS:
Fever: (-) Chills: (+) Earache: (-) Sore Throat: (-)
Cough: (-) Chest Pain: SOB: Hemoptysis:
Vomiting: (-) Diarrhea: Nausea: Constipation:
Dysuria: (-) Rash: Muscle Pain: Joint Pain:
Fatigue: (+) Depression: Anxiety:
CFS & FM: SRF see full symptom questionnaire

Interval History: Palpitations
Past Surgeries: none
Social History: Smoke: (-) ETOH: Drug:

Physical Exam: General: looks well full PE done

Eyes: ✓ normal
Ears: ✓ normal
Throat: ✓ normal
Neck: ✓ normal bruits: thyroid:
Chest: ✓
Heart: ✓
Abdomen: ✓
Skin: ✓
GU: Neuro:
Psych: Mood: Affect:

Wt: 243 lbs Hgt: HC:
T: 95.4 P: 96 R: 16 BP: 124/72

SF-36 See letter
EKG - no arrhythmia
discuss new treatment

Counseling Done (time/min): Disability

Assessment
1) orthostatic hypotension
2) dizziness
3)
4)
5)

Plan: 1) letter dictated
2) Consider Pyridostigmine
3)
4)
5)

Time spent:

Date of Visit: 7/8/05
Age: 45
Med Allergies: Codeine, Iodine NAME: Mazie John

David S. Bell MD, FAAP
77 South Main Street,
Lyndonville, NY 14098
585-765-2060

Medications: on same meds.
Trazadone @ hs.

HPI & Chief Complaint: Symptoms: CFS MV
Location:
Quality:
Severity:
Duration:
Other:

ROS:
Fever: ✓ Chills: ✓ Earache: ✓ Sore Throat: ✓
Cough: ✓ Chest Pain: ✓ SOB: ✓ Hemoptysis: ✓
Vomiting: ✓ Diarrhea: ✓ Nausea: ✓ Constipation: ✓
Dysuria: ✓ Rash: ✓ Muscle Pain: ✓ Joint Pain: ✓
Fatigue: Depression: Anxiety:

CFS & FM: see full symptom questionnaire

Interval History:

Past Surgeries:

Social History: Smoke: ETOH: Drug:

Physical Exam: General:

Wt: 242 lbs. Hgt: HC:
T: 97.8 P: 82 R: 20 BP 132/72

Eyes: ✓ normal
Ears: ✓ normal
Throat: ✓ normal
Neck: ✓ normal bruits: thyroid:
Chest: ✓
Heart: ✓
Abdomen: ✓
Skin: ✓
GU: ✓ Neuro:
Psych: Mood: Affect:

Counseling Done (time/min): 60 min | sec directed as 30 min ORF

Assessment
1) Atherosclerotic hypertension
2)
3)
4)
5)

Plan: 1) pravachol 40 mg
2) Vicodin 10/500
3)
4)
5)

Time spent:

David S. Bell, M.D.
77 South Main Street
P.O. Box 495
Lyndonville, New York 14098
Telephone: (585) 765-2060

June 6, 2005

To Whom It May Concern:

John Magee was seen on June 1st of 2005 in recheck of his chronic fatigue syndrome. Overall, his symptoms continue to be very severe. Specific disability questionnaires were administered. His Krupp Fatigue score is 56, which is in the disabled range. His modified Karnofsky score is 25 percent--also in the disabled range. The pattern of symptoms continues to be consistent for chronic fatigue syndrome.

SF-36 was administered and the subscores were as follows:

(1) PF 35
(2) RP 0
(3) BP 32
(4) GH 30
(5) VT 20
(6) SF 25
(7) RE 100
(8) MH 72.

Interpretation: The SF-36 is an extremely well validated indicator of overall disability. On today's visit John did not know the scoring system nor did he understand how this questionnaire is used. His scores show marked disability. Specifically, in the six different domains of physical functioning he is disabled beyond what is usually seen in end-stage cardiac or pulmonary disease. Of interest, the two domains looking at emotional functioning, the RE and the MH, are above normal. This would imply that he has a physical illness which is causing him severe debility and he has no emotional component to his disability.

If you have specific questions, please do not hesitate to call.

Very truly yours,

David S. Bell, M.D.

DSB:ds
Dictated, not read.

	PF	RP	BP	GH	VT	SF	RE	MH
1. 1=100; 2=75; 3=50; 4=25; 5=0				0				
2. 1=100; 2=75; 3=50; 4=25; 5=0								
3. 1=0; 2=50; 3=100	0							
4. 1=0; 2=50; 3=100	0							
5. 1=0; 2=50; 3=100	50							
6. 1=0; 2=50; 3=100	0							
7. 1=0; 2=50; 3=100	50							
8. 1=0; 2=50; 3=100	50							
9. 1=0; 2=50; 3=100	0							
10. 1=0; 2=50; 3=100	50							
11. 1=0; 2=50; 3=100	100							
12. 1=0; 2=50; 3=100	50							
13. 1=0; 2=100		0						
14. 1=0; 2=100								
15. 1=0; 2=100								
16. 1=0; 2=100								
17. 1=0; 2=100							100	
18. 1=0; 2=100								
19. 1=0; 2=100								
20. 1=100; 2=75; 3=50; 4=25; 5=0						25		
21. 1=100; 2=80; 3=60; 4=40; 5-20; 6=0			40					
22. 1=100; 2=75; 3=50; 4=25; 5=0			25					
23. 1=100; 2=80; 3=60; 4=40; 5-20; 6=0					20			
24. 1=0; 2=20; 3=40; 4=60; 5=80; 6=100								100
25. 1=0; 2=20; 3=40; 4=60; 5=80; 6=100								50
26. 1=100; 2=80; 3=60; 4=40; 5-20; 6=0								40
27. 1=100; 2=80; 3=60; 4=40; 5-20; 6=0					20			
28. 1=0; 2=20; 3=40; 4=60; 5=80; 6=100								100
29. 1=0; 2=20; 3=40; 4=60; 5=80; 6=100					20			
30. 1=100; 2=80; 3=60; 4=40; 5-20; 6=0								40
31. 1=0; 2=20; 3=40; 4=60; 5=80; 6=100					20			
32. 1=0; 2=25; 3=50; 4=75; 5=100						25		
33. 1=0; 2=25; 3=50; 4=75; 5=100				75				
34. 1=100; 2=75; 3=50; 4=25; 5=0				25				
35. 1=0; 2=25; 3=50; 4=75; 5=100				50				
36. 1=100; 2=75; 3=50; 4=25; 5=0				0				
	35	0	32	30	20	25	100	72
	10	4	2	5	4	2	3	5

PF = physical functioning RP = Role limitations – physical BP = Bodily pain
GH = General health perceptions VT = vitality/energy SF = social functioning
RE = Role limitations – emotional MH = Mental health

MEDICAL SOURCE STATEMENT (physical)

Name of Individual: John C. Magee Jr.

Social Security Number: 088-54-4213

Please circle, mark, or complete the following items based on your clinical evaluation of the patient, objective diagnostic assessments you have reviewed, and subjective symptoms, as appropriate. Assess the patient's realistic capacity to perform each identified activity.

Definitions: **Occasionally** : 1% to 33% of a workday (up to 2⅔ hours)
Frequently : 34% to 66% of a workday (2⅔ hours to 5⅓ hours)
Continually : 67% to 100% of a workday (at least 5⅓ hours)

I. EXERTIONAL LIMITATIONS

A. This patient can lift/carry:

	Never	Occasionally	Frequently	Continually
1) Less than 10 lbs.		✓		
2) 10 lbs.				
3) 20 lbs.				
4) 50 lbs.				
5) 100 lbs. or more				

B. This patient has the realistic capacity to perform the following activities, during an 8-hour competitive workday, (with normal breaks), for a total of:

	HOURS
(1) Sit –	1 (2) 3 4 5 6 7 8
(2) Stand or walk –	(1) 2 3 4 5 6 7 8

C. Must this patient periodically alternate sitting and standing or walking? Yes ✓ No ____

If so, how often must those alternations occur? At least every:

____ 15 min. ____ 30 min. ____ 45 min. ____ 1 hour ____ 2 hours

must lie down

D. This patient may use feet for operating leg controls, including push and/or pull, as follows:

	Never	Occasionally	Frequently	Continually
1) Right leg		✓		
2) Left leg		✓		
3) Both legs		✓		

E. This patient is required to elevate leg(s):

	Never	Occasionally	Frequently	Continually
1) Right leg		✓		
2) Left leg		✓		

F. Must this patient use a hand-held assistive device? ___ Yes ___ No
If so, how often must the device be used?
___ Constantly ___ Periodically ✓ Only in Certain Situations

G. This patient may use hands in the following ways:

	Never	Occasionally	Frequently	Continually
1) Simple grasping		✓		
2) Push and/or pull		✓		
3) Reaching all directions (including overhead)		✓		
4) Handling (gross manipulation)		✓		
5) Fingering (fine manipulation)		✓		
6) Feeling (skin receptors)		✓		

II. POSTURAL LIMITATIONS

A. This patient is able to:

	Never	Occasionally	Frequently	Continually
1) Bend	✓			
2) Climb	✓			
3) Balance	✓			
4) Stoop	✓			
5) Kneel	✓			
6) Crouch	✓			
7) Crawl	✓			
8) Reach overhead		✓		
9) Extend arms out		✓		
10) Squat		✓		

III. ENVIRONMENTAL LIMITATIONS

This patient has the following restrictions in environmental exposure:

	Unlimited	Avoid Concentrated Exposure	Avoid Even Moderate Exposure	Avoid All Exposure
A) Extreme cold		✓		
B) Extreme heat		✓		
C) Wetness		✓		
D) Humidity		✓		
E) Noise		✓		
F) Vibration		✓		
G) Fumes, Odors, Dust, Gases, Poor Ventilation, etc.		✓		
H) Unprotected Heights		✓		
I) Moving Machinery		✓		

IV. COMMUNICATIVE LIMITATIONS

Is this patient limited in the ability to:

Hear ____ Yes ✓ No
Speak ____ Yes ✓ No

V. DOES THE PATIENT HAVE VISUAL LIMITATIONS? ____ Yes ✓ No

VI. SUBJECTIVE SYMPTOMS

This patient has a condition or combination of conditions which has resulted in the following subjective symptoms:

	Never	Occasionally	Frequently	Continually
(1) Fatigue				✓
(2) Pain				✓
(3) Shortness of breath			✓	
(4) Vertigo				✓
(5) Other				✓

(please identify) _____

VII. WERE THE ABOVE-DESCRIBED LIMITATIONS PRESENT SINCE AT LEAST 12-15-03?
____ Yes ____ No

If not, when did the above-described limitations begin? _____

VIII. IDENTIFY THE OBJECTIVE FINDINGS WHICH COULD REASONABLY BE EXPECTED TO CAUSE THE ABOVE IDENTIFIED LIMITATIONS.

X DAVID S. BELL MD
Physician's Name (Typed or Printed)

X
Physician's Signature

X 6/1/05
Date

viaHealth

Rochester General Hospital Laboratory
Theodor K. Mayer, MD PhD

1425 Portland Ave.
Rochester, NY 14621

MAIL

CLINICAL LABORATORIES
Client Services

(585)922-4451

Final Report

COLLECTION DATE & TIME	REPORT DATE	ACCESSION NUMBER	LOCATION
06/29/2005 09:10	07/06/2005 03:32	30293413	RHF

PHYSICIAN	PATIENT INFORMATION
BELL, DAVID S 77 SOUTH MAIN STREET BOX 495 LYNDONVILLE NY 14098 MAIL	MAGEE, JOHN MR# :R0000821034 SEX: M DOB :12/07/1959 AGE: 45 CHART:NG ADM: 06/29/05 PHONE:(585)624-9306

TEST	FLAG	RESULTS	REFERENCE RANGE
HEMATOLOGY			
CBC/ROUTINE HEMATOLOGY			
WBC		7.5 10^3/uL	4.0-11.0
RBC		4.96 10^6/uL	4.40-6.20
HGB		14.6 g/dL	13.0-18.0
HCT		44 %	40-52
MCV		89 fL	80-100
MCH		29.5 pg	26.0-34.0
MCHC		33.3 g/dL	32.0-36.0
RDW		12.1 %	0.0-15.2
PLATELET COUNT		244 10^3/uL	150-450
WBC DIFFERENTIAL			
NEUTROPHILS		60 %	45-75
LYMPHOCYTES		28 %	15-45
MONOCYTES		9 %	0-15
EOSINOPHILS		2 %	0-5
BASOPHILS		0 %	0-3
NEUTROPHIL #		4.5 10^3/uL	1.8-8.0
LYMPHOCYTE #		2.1 10^3/uL	1.0-4.8
MONOCYTE #		0.7 10^3/uL	0.1-1.0
EOSINOPHIL #		0.1 10^3/uL	0.0-0.6
BASOPHIL #		0.0 10^3/uL	0.0-0.2
CHEMISTRY			

JUL 07 2005

24435 (Remlab) (rev. 9/99)

Legend: L-Low H-High C-Critical T-Toxic X-absurd AB-abnormal

Site codes:	B-Lakeside	G-Genesee	R-RGH	W-Newark Wayne	a-ARUP
	156 West Ave	224 Alexander St	1425 Portland Ave	111 Driving Park Ave	500 Chipeta Way
	Brockport,NY	Rochester, NY	Rochester,NY	Newark, NY	Salt Lake City, UT

PRINTED 07/06/2005 03:37

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TEST	FLAG	RESULTS		REFERENCE RANGE
GENERAL CHEMISTRY				
GLUCOSE		90	mg/dL	65-110
BUN		16	mg/dL	8-20
CREATININE		0.8	mg/dL	0.7-1.4
GFR CAUCASIAN		111	mL/min	63-147
GFR BLACK		135	mL/min	63-147
For both GFR CAUCASIAN and GFR BLACK, the accuracy of the GFR calculation is contingent on a stable level of serum creatinine. A GFR less than 60 may alter clinical management decisions. A GFR within the age-adjusted reference range does not exclude kidney disease.				
SODIUM		142	mEq/L	135-145
POTASSIUM		4.3	mEq/L	3.5-5.0
CHLORIDE		102	mEq/L	98-108
CO2		29	mEq/L	22-30
ANION GAP		11	mEq/L	7-16
CALCIUM		9.1	mg/dL	8.5-10.2
TOTAL PROTEIN		7.1	g/dL	6.4-8.2
ALBUMIN		4.4	g/dL	3.2-5.0
GLOBULIN		2.7	g/dL	2.7-4.3
ALK PHOS		72	U/L	30-135
AST		20	U/L	7-37
ALT		45	U/L	20-65
BILI, TOTAL		0.6	mg/dL	0.0-1.0
CHOLESTEROL	H	252	mg/dL	100-200
TRIGLYCERIDES		155	mg/dL	30-190
HDL CHOLESTEROL		51	mg/dL	35-130
LDL (calc)	H	170	mg/dL	65-130
CHOL/HDL RATIO		4.9		

CHD Risk Group	CHOL/HDL RATIO Men	Women
Lowest	<3.8	<2.9
Low	3.8-4.7	2.9-3.6
Moderate	4.8-5.9	3.7-4.6
High	>5.9	>4.6

Legend: L-Low H-High C-Critical T-Toxic X-absurd AB-abnormal

Site codes: B-Lakeside	G-Genesee	R-RGH	W-Newark Wayne	a-ARUP
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TEST	FLAG	RESULTS		REFERENCE RANGE
ENDOCRINE CHEMISTRY				
TSH		2.23	uIU/mL	0.35-5.50
ANTI-TPO AB		<5	IU	0-4
Anti-TPO Ref. Range:..IU				
Negative:.....<5				
Indeterminate:.....5-10				
Positive:.....>10				
ANTI-THYROGLOBULIN AB		<25	IU	0-24
Anti-Thyroglobulin Ref. Range:..IU				
Negative:.....<25				
Indeterminant:.....25-38				
Positive:..... >38				
CORTISOL, RANDOM	H	23.9	ug/dL	3.0-23.0
Cortisol Reference Range: AM: 5-23 ug/dL; PM: 3-16 ug/dL				

24435 (Remlab) (rev. 9/99)

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Site codes: B-Lakeside	G-Genesee	R-RGH	W-Newark Wayne	a-ARUP
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Brockport,NY	Rochester, NY	Rochester,NY	Newark, NY	Salt Lake City, UT

PRINTED 07/06/2005 03:37

ME/CFS Clinical Study Group Questionnaire

David S. Bell MD, FAAP
77 South Main Street,
Lyndonville, NY 14098
716-765-2060
fax 716-765-2067

0507130415

Name: John Mayer **Age:** 45 **Date:** 6/2/05

Thank you for completing this questionnaire, which is being used to collect information about ME/CFS/FM in several clinical practices. If used for research purposes, your confidentiality will be maintained. There are a number of separate sections, and each is designed to give information concerning your pattern of symptoms, and this questionnaire should take about a half an hour to complete. Please bring the completed questionnaire to your next office visit. Do not hesitate to call if you have specific questions.

1. Please list all medications you are taking:
wellbutrin SR
celexa
vicodine – PRN
trazodone –
Amidrine – PRN
cosopt – 1drop/eye/2x day

2. Since your last visit here, have you been diagnosed with any other illnesses? If yes, please describe:
no

3. Are you working or in school full time, part time, or not at all?
not at all

4. Is there any significant change in your pattern of symptoms since your last visit?
Headaches have gotten worse

Krupp Fatigue Questionnaire

Please read each statement and circle a number from 1 to 7, depending on how appropriate the statement is to you in the preceding week. A low value indicates that the statement is not very appropriate whereas a high value indicates agreement.	Score
1. My motivation is lower when I am fatigued.	1 2 3 4 5 6 (7)
2. Exercise brings on my fatigue.	1 2 3 4 5 6 (7)
3. I am easily fatigued.	1 2 3 4 (5) 6 7
4. Fatigue interferes with my physical functioning.	1 2 3 4 5 (6) 7
5. Fatigue causes frequent problems for me.	1 2 3 4 5 (6) 7
6. My fatigue prevents sustained physical functioning.	1 2 3 4 5 (6) 7
7. Fatigue interferes with carrying out certain duties and responsibilities.	1 2 3 4 5 6 (7)
8. Fatigue is among my three most disabling symptoms.	1 2 3 4 5 (6) 7
9. Fatigue interferes with my work, family, or social life.	1 2 3 4 5 6 (7)

(56)

Activity Scale: Please check the one area that most closely describes your activity over the past week. If your activity varies during a typical week, check the area that describes your average daily activity.

_____ 100%: I feel very well and able to do all activities. I am not limited by fatigue or exhaustion at all.

_____ 90%: I feel well but will have mild fatigue on heavy exertion or exercise that disappears with rest.

_____ 80%: I generally feel well, but notice mild fatigue fairly often. It does not prevent or interrupt normal activities during the day. I still can work or go to school full time.

_____ 70%: I feel OK most of the time but frequently have fatigue which interferes with my daily activities. I have to rest more than I should, but I still can work or go to school full time.

_____ 60%: I frequently feel ill and have had to reduce my activities because of fatigue and exhaustion. I work or go to school but it is difficult and I need to rest more often. The fatigue clearly interferes with my daily activities.

_____ 50%: I feel moderately ill much of the time, and the fatigue and exhaustion has a definite impact on my life. I am not able to consistently put in eight hours of work or school every day. I have had to reduce my daily activities substantially.

_____ 40%: I feel ill nearly all of the time and the fatigue and exhaustion have forced me to limit my activities or carefully plan them. I cannot work or go to school except for part time. I have to rest much of the day.

X 30%: I feel ill most of the time and am unable to even leave the house except for a few hours a day. I am unable to work or go to school. I spend most of the day resting.

X 25%

X 20%: I feel extremely ill nearly all day, and am unable to leave the house except rarely. I spend nearly all day resting. I am able to do light activities such as preparing food for only one or two hours a day.

_____ 10%: I am bed-ridden and feel extremely ill all of the time. I need help with activities of daily living.

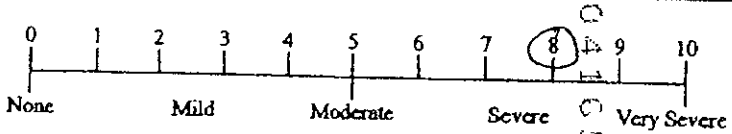
_____ 0%: I am extremely ill all of the time and must have constant care for activities such as eating or bathing. I cannot prepare my own food, and do not leave the house.

Thank you for completing this questionnaire.

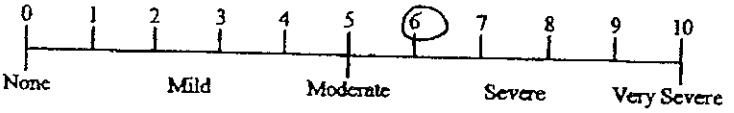
Krupp: _____ SF-36: _____ 9 item VAS: _____ Modified Karnofsky: _____

Specific Symptom Severity: Please mark the scale the degree that the symptom has affected you in the past week. If the symptom varies day-to-day, mark an average severity.

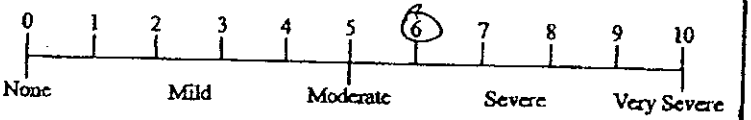
Impaired Memory or Concentration



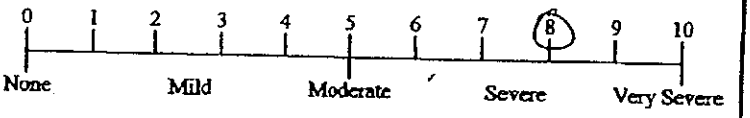
Recurrent sore throat



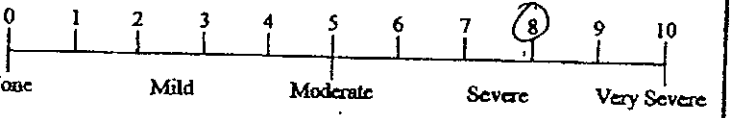
Tenderness in the Lymph Nodes



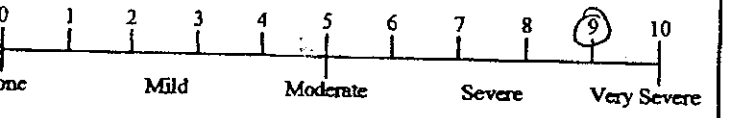
Muscle tenderness



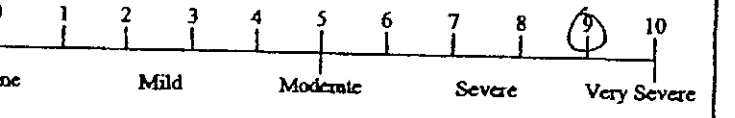
Joint Pain Without Swelling or Redness



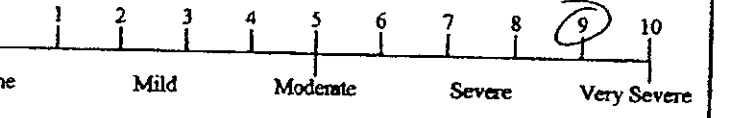
Headache



Unrefreshing sleep



Post-exertional Malaise



RAND 36-Item Health Survey 1.0 RAND® is a registered trademark.

1. In general, would you say your health is:	
Excellent	1
Very good	2
Good	3
Fair	4
Poor	5

2. Compared to one year ago, how would your rate your health in general now?	
Much better now than one year ago	1
Somewhat better now than one year ago	2
About the same	3
Somewhat worse now than one year ago	4
Much worse now than one year ago	5

The following items are about activities you might do during a typical day. Does **your health now limit you** in these activities? If so, how much? **(Circle One Number on Each Line)**

	Yes, Limited a Lot	Yes, Limited a Little	No, Not limited at All
3. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	[1]	[2]	[3]
4. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	[1]	[2]	[3]
5. Lifting or carrying groceries	[1]	[2]	[3]
6. Climbing several flights of stairs	[1]	[2]	[3]
7. Climbing one flight of stairs	[1]	[2]	[3]
8. Bending, kneeling, or stooping	[1]	[2]	[3]
9. Walking more than a mile	[1]	[2]	[3]
10. Walking several blocks	[1]	[2]	[3]

11. Walking one block	[1]	[2]	[3]
12. Bathing or dressing yourself	[1]	[2]	[3]

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health? **(Circle One Number on Each Line)**

	Yes	No
13. Cut down the amount of time you spent on work or other activities	1	2
14. Accomplished less than you would like	1	2
15. Were limited in the kind of work or other activities	1	2
16. Had difficulty performing the work or other activities (for example, it took extra effort)	1	2

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)? **(Circle One Number on Each Line)**

	Yes	No
17. Cut down the amount of time you spent on work or other activities	1	2
18. Accomplished less than you would like	1	2
19. Didn't do work or other activities as carefully as usual	1	2

20. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups? (Circle One)

Not at all 1 Slightly 2 Moderately 3 Quite a bit 4 Extremely 5

21. How much bodily pain have you had during the past 4 weeks? (Circle One)

None 1 Very mild 2 Mild 3 Moderate 4 Severe 5 Very severe 6

22. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)? (Circle One Number)

Not at all 1 A little bit 2 Moderately 3 Quite a bit 4 Extremely 5

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks . . . (Circle One Number on Each Line)

	All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
23. Did you feel full of pep?	1	2	3	4	(5)	6
24. Have you been a very nervous person?	1	2	3	4	5	(6)
25. Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	(5)	6
26. Have you felt calm and peaceful?	1	2	3	(4)	5	6
27. Did you have a lot of energy?	1	2	3	4	(5)	6
28. Have you felt downhearted and blue?	1	2	3	4	5	(6)
29. Did you feel worn out?	1	(2)	3	4	5	6
30. Have you been a happy person?	1	2	3	(4)	5	6
31. Did you feel tired?	1	(2)	3	4	5	6

32. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)? (Circle One)

All of the time 1 Most of the time (2) Some of the time 3 A little of the time 4 None of the time 5

How TRUE or FALSE is <u>each</u> of the following statements for you. (Circle One Number on Each Line)

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
33. I seem to get sick a little easier than other people	1	2	3	(>4)	5
34. I am as healthy as anybody I know	1	2	3	(4)	5
35. I expect my health to get worse	1	2	(3)	4	5
36. My health is excellent	1	>2	3	4	(5)

Metropolitan Life Insurance Company

MetLife®

MetLife Disability
PO Box 14590
Lexington, KY 40511-4590

0507130416554

June 24, 2005

John Magee
71 Ontario St
Honeoye Falls, NY 14472-1123

RE: ***Long Term Disability***
Claim No.: ***640407128904***
Group No.: ***303299***

Dear Mr. Magee:

We are writing in reference to the your claim for Long Term-Disability (LTD) benefits.

We require additional information describing your current medical condition to enable us to evaluate your claim for continuation of Long Term Disability Benefits.

In accordance with the terms of your group plan, we are asking you to please have all your treating physician(s) provide us with the following medical information from January 2005 through the present:

- Copies of all office notes/progress notes
- Copies of a list of all medications and dosages
- Copies of all test results such as x-rays, MRI's, lab results, etc.
- What specific objective functional deficits hinder the patient's ability to return to work?
- What is the present and future course of treatment?
- Do you have any estimated return to work date?

We ask that you contact his/her office promptly to be sure this information is submitted on behalf of your claim. Failure to provide the requested information could result in suspension of your benefits.

Please note that any cost associated with this request is, as always, the responsibility of the claimant.

Your cooperation is appreciated.

Sincerely,

Peter Knoth

Peter Knoth (PK)
Case Management Specialist
Met DisAbility
Tel: (800) 300-4296
Fax: (800) 230-9531

7/12/05 Copies to Atty

Metropolitan Life Insurance Company

MetLife®

MetLife Disability
PO Box 14590
Lexington, KY 40511-4590

June 24, 2005

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Group No.: 303299

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Sincerely,

Peter Knoth

Peter Knoth
Case Management Specialist
Met DisAbility
Tel: (800) 300-4296
Fax: (800) 230-9531

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Metropolitan Life Insurance Company

OGC

MetLife®

MetLife DisAbility
PO Box 14590
Lexington, KY 40511-4590

1/3/2005

Occudata Inc.
5700 BROADMOOR SUITE 310
MISSION, KS 66202

RE: JOHN MAGEE
Claim: Metropolitan Life Insurance Company 640407128904
Group number: 303299
Phone: 5856249306
Policyholder: ITT INDUSTRIES

Dear Sirs:

We have received the necessary authorization forms and are enclosing copies of the Medical, Vocational and Social Security information in our file.

Please include this information with the claim for SSDIB and keep us advised as to the status of the claim for Social Security Disability Benefits.

Thank you for your attention to this matter.

Yours truly,

Ed Herrin
SS Specialist
Social Security Unit
(315) 792-2351

OG-C

041227 1340

Metropolitan Life Insurance Company

MetLife®

MetLife Disability
PO Box 14590
Lexington, KY 40511-4590

December 23, 2004

John Magee
71 Ontario St.
Honeoye Falls, NY 14472

RE: ITT Industries, Inc.
Long Term Disability Benefits
Claim No.: 640407128904
Group No.: 303299

Dear Mr. Magee:

This letter is in regards to the phone call we had on December 23, 2004. Enclosed is a copy of the Independent Physicians Consultant (IPC) review you requested.

Should you have any questions, please call the toll-free number listed below.

Sincerely,

Peter Knoth
Case Management Specialist
Met DisAbility
(800) 300-4296 - Phone

MED / IPC RPT

PHYSICIAN CONSULTANT REVIEW

DATE OF REVIEW: December 13, 2004

CLAIMANT NAME: MAGEE, JOHN

CLAIM NUMBER: 640407128904

EMPLOYER: ITT Industry

EMPLOYER GROUP ID NUMBER: 303299

CLAIMANT SS#: 088-54-4213

DOB: 12/07/59 (45Y)

REFERRAL SOURCE: Kathryn Snell, Nurse Coordinator, Utica office

Reason for Referral: This 45-year-old Program Assurance Manager is an active case with long-term disability and is being reviewed for his disability in relationship to any and all occupations. He is under the care of a Dr. Alice Tariot and a telephone conference has been requested and occurred on 12/09/04.

Diagnoses of Record: Chronic fatigue syndrome (CFS) and major depressive disorder recurrent with suicidal ideation, but no suicidal plan. There is no additional diagnosis offered under DSM-IV, but we do have office notes and information provided by a Dr. David S. Bell whose specialty is chronic fatigue syndrome and who is treating for this condition, and who has also provided additional information.

Summary of Activity/Documents Reviewed: All information provided through the A.C.S., including ongoing office notes from Dr. Tariot, including a Mini-Mental Status Examination and office notes up to and including October 27, 2004 and a letter of February 5, 2004 which is a summary of the treatment. There are several letters and progress notes, as well as examinations by David Bell and a considerable number of laboratory tests provided which confirms the presence of a chronic fatigue syndrome dating back as far as the year 2000.

Telephone Calls: A telephone conference was requested and was accomplished with Dr. Alice Tariot.

File History/Summary: EE is a 45-year-old male whose last day of work is 11/26/03, and who has a diagnosis of chronic fatigue syndrome, as well as a major depressive disorder. Primary doctor is Dr. Bell for chronic fatigue and EE is being treated by Dr. Alice Tariot for the diagnosis of depression. He has subjective complaints of pain and exhaustion which first appeared in 1995. Current symptoms have worsened to where he

MED / IPC RPT

PHYSICIAN CONSULTANT REVIEW

is not able to return to work as he feels ill and activity is restricted. Medications include Wellbutrin, Lexapro, Klonopin, and additional medications for pain and for CFS. Please review file for depression and provide an opinion as to the severity of his symptoms and diagnosis.

Questions Posed and Answers:

A. Q: Based on your review of the medical documentation on file and a phone call with Dr. Tariot, provide your opinion of the objective clinical findings which support a severity of impairment at this time. Are the symptoms and impairments substantiated by objective clinical findings?

B. Q: How consistent with the clinical evidence presented is the stated diagnosis if applicable under Axis I and DSM-IV?

C. Q: Do the symptoms listed correlate with those usually seen in this condition

D. Q: Provide any further medical recommendations.

Question A: The information provided from the record does indicate that this is a documented chronic fatigue syndrome which is currently under treatment by a Dr. David S. Bell who has provided extensive information establishing this condition. The present reviewer defers his review to an IPC whose specialty is more directly related to chronic fatigue syndrome. The psychiatric aspects of the case as discussed with Dr. Tariot and as verified in her descriptions in her office notes would indicate that this is the primary condition and his psychiatric condition is characterized by a partial compliance with medication. There are several references to depression, suicidal ideation, angry outbursts towards members of the family, particularly a son, and suicidal ideation related to his feelings that he is a nonproductive member of society and accordingly not a worthwhile person. There is considerable weeping, guilt, and self-reported information related to his chronic fatigue syndrome which Dr. Tariot considers as part of his depressive syndrome. In her opinion the depressive elements are of a severity that would prevent him from performing the duties of his own job or any occupation at the present time. She also is of the opinion that if his fatigue syndrome would improve his depression it would be more manageable. For this reason the present reviewer is of the opinion that the objective clinical findings do support a severity of impairment that would prevent the EE from performing the duties of any job. The impairments are substantiated by objective clinical findings, as well as self-reported information. There are evidences that there are contacts

MED / IPC RPT

PHYSICIAN CONSULTANT REVIEW

with the wife and with the social work therapist on an ongoing basis so that appropriate and adequate treatment is being provided.

Question B: There is consistent compelling evidence that there is a DSM-IV diagnosis of major depressive disorder related to a chronic fatigue syndrome that would prevent the EE from performing the duties of his own job.

Question C: Yes

Question D: The present information does substantiate an ongoing condition limiting the EE's capacity to return to some form of employment at the present time. It is the present reviewer's opinion that the condition needs ongoing review, possibly on a yearly or half-yearly basis.

ERNEST GOSLINE, M.D., F.A.P.A. (DL)
Board Certified Psychiatrist

EG/JT

PHYSICIAN CONSULTANT REVIEW

DATE OF REVIEW: December 13, 2004

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CLAIM NUMBER: 640407128904

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EMPLOYER GROUP ID NUMBER: 303299

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PHYSICIAN CONSULTANT REVIEW

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MED / IPC RPT

PHYSICIAN CONSULTANT REVIEW

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ERNEST GOSLINE, M.D., F.A.P.A. (DL)
Board Certified Psychiatrist

EG/JT

041220017589

OCCUDATA, INC.
Social Security Disability Specialists

December 15, 2004

Financial Index for #640407128904

Mr. Ed Herrin
MetLife Disability
c/o ACS
P. O. Box 14590
Lexington, KY 40511-4590

Re: Claimant : John Magee
Our File No. : OC12945NY

Dear Mr. Herrin:

We are pleased to report the above-referenced claimant has given us written authorization to proceed with a review of their medical information. A copy of this authorization is enclosed for your records.

Please send us a copy of your file so that we may include it with the records we obtain to develop the claimant's case for Social Security disability benefits. We will keep you advised as to the status of Mr. Magee's claim. Mr. Magee received a Social Security disability benefits denial at the initial level on 11/12/04. Since SSA is skipping the reconsideration level, we filed a protective appeal at the hearing level on 11/19/04, and will be assisting him with the remaining appeal forms.

Thank you for this referral. If you have any questions, please feel free to call.

Sincerely,

OCCUDATA, INC.

Diana Owens
Disability Coordinator

DO/skm

Enclosures: SSA-1696-U4 (copy); Fee Agreement (copy); Release Form

5700 Broadmoor St., Ste. 310 • Mission, KS 66202-2405 • (913) 262-6555 • FAX (913) 262-4066
Email: dibrep@occudata.com Website: www.occudata.com

Financial Index for #6404071280004
041220C17589

OCCUDATA, INC.
Social Security Disability Specialists

RECEIVED
DEC 13 2004
OCCUDATA, INC.

AUTHORIZATION FOR RELEASE OF
LONG TERM DISABILITY INFORMATION

CLAIMANT: John C. Magee
SSN : 088-54-4213

I HEREBY AUTHORIZE METROPOLITAN LIFE INSURANCE COMPANY TO RELEASE INFORMATION FROM THEIR LONG TERM DISABILITY FILE TO OCCUDATA, INC. AT 5700 BROADMOOR, SUITE 310, MISSION, KANSAS 66202 FOR USE IN MY CLAIM FOR SOCIAL SECURITY DISABILITY BENEFITS.

SIGNATURE

12/9/04
DATE

5700 Broadmoor St., Ste. 310 • Mission, KS 66202-2405 • (913) 262-6555 • FAX (913) 262-4066
Email: dibrep@occudata.com Website: www.occudata.com

Social Security Administration — Financial Index for #6400672890A

Please read the back of the last copy before you complete this form. Form Approved OMB No. 0960-0527

Name (Claimant) (Print or Type): John C. Magee | Social Security Number: 088-54-4213

Wage Earner (If Different) | Social Security Number

Part I APPOINTMENT OF REPRESENTATIVE

I appoint this person, Jean C. Owen, Esq./Occudata, Inc. (Name and Address)

to act as my representative in connection with my claim(s) or asserted right(s) under:

- [X] Title II (RSDI)
- [ ] Title XVI (SSI)
- [ ] Title IV FMSHA (Black Lung)
- [X] Title XVIII (Medicare Coverage)
- [ ] Title VIII (SVB)

This person may, entirely in my place, make any request or give any notice; give or draw out evidence or information; get information; and receive any notice in connection with my pending claim(s) or asserted right(s).

- [ ] I am appointing, or I now have, more than one representative. My main representative is _____ (Name of Principal Representative)

Signature (Claimant): John C. Magee | Address: 71 Ontario St Hamburg Falls NY 14472

Telephone Number (with Area Code): (585) 627-9306 | Fax Number (with Area Code) | Date: 12/13/04

Part II ACCEPTANCE OF APPOINTMENT

I, Jean C. Owen, hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not disqualified from representing the claimant as a current or former officer or employee of the United States; and that I will not charge or collect any fee for the representation, even if a third party will pay the fee, unless it has been approved in accordance with the laws and rules referred to on the reverse side of the representative's copy of this form. If I decide not to charge or collect a fee for the representation, I will notify the Social Security Administration. (Completion of Part III satisfies this requirement.)

- [X] I am an attorney.
- [ ] I am not an attorney. (Check one.)

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

Signature (Representative): Jean C. Owen | Address: OCCUDATA, INC. 5700 Broadmoor Suite 310 Mission, KS 66202 913/262-6555

Telephone Number (with Area Code) | Fax Number (with Area Code) | Date: 12/13/04

Part III (Optional) WAIVER OF FEE

I waive my right to charge and collect a fee under sections 206 and 1631(d)(2) of the Social Security Act. I release my client (the claimant) from any obligations, contractual or otherwise, which may be owed to me for services I have provided in connection with my client's claim(s) or asserted right(s).

Signature (Representative) | Date

Part IV (Optional) ATTORNEY'S WAIVER OF DIRECT PAYMENT

I waive only my right to direct payment of a fee from the withheld past-due retirement, survivors, disability insurance or black lung benefits of my client (the claimant). I do not waive my right to request fee approval and to collect a fee directly from my client or a third party.

Signature (Attorney Representative) | Date

FEE AGREEMENT ATTACHED

Form SSA-1696-U4 (5-2003) EF (5-2003) Destroy Prior Editions (See Important Information on Reverse) FILE COPY

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